Look Back on the ICD-10 Transition: Crisis Averted or Imaginary?

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The transition to ICD-10-CM/PCS (ICD-10) was an update to the antiquated 30-year-old ICD-9-CM coding system that was made to reflect changes in the practice of medicine that have occurred over the past three decades. It is a next-generation coding system that modernizes and expands the capacity of the healthcare industry to keep pace with changes in medical practice and healthcare delivery by providing higher quality information for measuring service quality, outcomes, safety, and efficiency.

What should have been a routine administrative update somehow became a highly charged political issue fueled by dire predictions of widespread chaos and cataclysmic system-wide failure as a result of moving forward with ICD-10.

Back in 2003, after two years of hearings, the National Committee on Vital and Health Statistics recommended that the Department of Health and Human Services (HHS) initiate the regulatory process for the adoption of ICD-10. A proposed rule for ICD-10 adoption was not issued until 2008, however, and the transition did not occur until October 2015 as the result of multiple delays.

Fortunately, despite all the misinformation, concerted efforts by the Centers for Medicare and Medicaid Services (CMS) and committed ICD-10 stakeholders kept the implementation of ICD-10 moving forward. The healthcare industry now knows that the transition to ICD-10 was largely a Y2K-like non-event with none of the dire predictions actually occurring. But why so? Was ICD-10 a crisis that was averted? Or was it just an imagined crisis? Or was it an intentionally fabricated crisis?

The US nearly failed to implement a critically needed update to its healthcare data infrastructure because of a systematic program of misinformation. This article will take a look back at the ominous pre-transition predictions, examine whether there was any truth to them, and discuss lessons learned that might help the healthcare industry avoid a similar fiasco the next time the industry faces the need to update a national code set standard.

Financial Disruption Predictions Examined

In the run-up to implementation of ICD-10, the following financial disruptions were predicted by some in the healthcare industry:

- Substantial cash flow disruptions and revenue shortfalls
- Significant increases in claims denials and rejections
- Major payment slowdowns
- Issues accessing care due to small physician practices going out of business because of the burdens imposed by ICD-10
- Reimbursement disruptions triggered by ICD-10 that would negatively impact the credit of hospitals, making it much more difficult to obtain loans with affordable interest rates
- Dual coding would be necessary in order to prevent catastrophic payment disruptions

In a 2014 survey of physicians, 50 percent felt that implementation of ICD-10 would cause severe administrative problems in their practices, and 75 percent thought ICD-10 would unnecessarily complicate coding.[1] Huge financial disruptions—including claims denials of 100 percent to 200 percent, payment delays that would grow by 20 percent to 40 percent, and a two-fold increase in claims error rates—were widely predicted. Estimates of cash flow disruption costs varied, with one often-cited source estimating a range of $23,000 for a small physician practice to more than $3 million for a large practice.[2]

However, in short, the "fear of denials, lost revenue, and work flow is nowhere to be seen," as stated in an article in *Physicians Practice* that examined ICD-10's impact on doctors after six months of use.[3] For the most part, claims have been successfully submitted and processed. There have been no reports of a high rate of claims denials or rejections, or big drops in the volume of claims submitted. There has been very little variance in denial or rejection rates, or the average paid amount per claim, for both private payers and Medicare.[4] In fact, Blue Cross Blue Shield of Florida reported an eight percent decline in claims denials between October and December 2015 over the same period the previous year.[5]

Metrics provided by CMS at the end of October 2015 and then again at the end of December 2015 showed no increase in Medicare claims denials or rejections over the historical baseline. And the percentage of claims rejected due to coding errors was lower after the ICD-10 transition.[6,7] Many private payers also reported few problems and low claim denial and rejection rates.[8,9] A survey comparing hospital financial metrics for the last three months of ICD-9-CM use with the first three months of ICD-10 use revealed little difference except for increased medical necessity denials. The increase in medical necessity denials was likely due in part to translation errors in Medicare National Coverage Determinations (NCDs), Local Coverage Determinations (LCD), and other payment policies.[10]

While some providers have reported increases in claims denial and rejection rates, these increases have been significantly lower than pre-ICD-10 predictions. Some medical specialties have experienced more transition challenges than others, such as a higher volume of denials resulting from NCD or LCD errors that impact certain specialties more than others.[11] Many providers have seen little or no difference in denial or rejection rates. For example, nearly half of participants in a physician practice survey saw no change in denial rates, and 44 percent saw a denial rate increase of less than 10 percent.[12] One physician practice cloud technology vendor reported especially good news—several weeks after the transition clearinghouse rejections and carrier level rejections had decreased from ICD-9-CM levels, and successful claims were at the highest level ever measured. The pre-adjudication carrier rejection average was 1.5 percent, far lower than the rate of 2.3 percent under ICD-9-CM.[13]

These statistics may suggest that providers are better at ICD-10 coding than they were at ICD-9-CM coding. ICD-10 training and clinical documentation improvement efforts aimed at increasing the accuracy and specificity of ICD-10 coding appear to have paid off. The low percentage of denied claims has been attributed to CMS granting a grace period during which claims would not be rejected or denied due to a lack of specificity, with many private payers following suit.[14] However, the CMS policy only applies to post-payment audits—not to prior authorization requests, prepayment reviews, or claims edits. Claims may still be denied if ICD-10 codes fail edits, don't support medical necessity, or don't meet coverage requirements. The CMS policy also only applies to physician or other practitioner claims billed under the Part B physician fee schedule. It does not apply to facility claims.

Complexities Caused by an Increased Number of ICD-10-CM Codes

Prior to implementation of ICD-10, the following coding complexities were predicted by some in the healthcare industry:

- Large number of codes will make ICD-10-CM excessively complex, impossible to learn, and difficult to use
- Expanded specificity in ICD-10-CM external cause codes would make the code set too complicated
- Level of detail in ICD-10-CM is not supported by the medical community
- Increase in the number of codes and expanded specificity would result in an increase in the number of miscoded and rejected claims
- Medically unnecessary tests would need to be performed in order to assign ICD-10-CM codes
- Widespread denials involving "unspecified" ICD-10-CM codes would occur

Physicians were concerned that they would have to contend with a five-fold increase in diagnosis codes, including an expansion of external cause of codes (e.g., the infamous "struck by an orca" code), that would make the code set nearly impossible to use. However, for many physician specialties, the increase in the number of codes is fairly modest and most of the codes contain the same detail familiar to users of ICD-9-CM.[15] Physicians have found that just as they didn't use all of the available ICD-9-CM codes, they only use the subset of ICD-10-CM codes applicable to their specialties and patient populations.

While some specialties have been hit harder with coding and documentation challenges than others, providers have found that electronic coding and documentation tools help with code selection and documentation requirements. Well-designed electronic

health records (EHRs) can support ICD-10 coding and documentation requirements through robust code search tools and documentation prompts.

The existence of rarely used codes has not interfered with day-to-day use of the ICD-10 code set. There have been no reports of the ICD-10-CM external cause codes making the code set unmanageable for providers. Many providers are not required to report external cause codes, and even when their use is required, only a limited subset will be used by any given provider. Some external cause codes will be limited to certain geographic regions, occupations, or other special circumstances.

While some providers have reported increased denials to the use of "unspecified" ICD-10-CM codes, many others have not noticed any changes with respect to the acceptance of these codes. There have been no reports of providers conducting medically unnecessary diagnostic tests in order to assign specific ICD-10-CM codes. As the *ICD-10-CM Official Guidelines for Coding and Reporting* state: "When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code… It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code."[16]

Adverse Impact on Coder and Clinician Productivity

Prior to implementation of ICD-10, the following adverse impacts on coding and clinician productivity were predicted:

- Huge drop in coding productivity would occur and would likely be long-term or even permanent
- Significant drop in clinician productivity would occur as a result of increased clinical documentation requirements

Some industry experts had suggested that hospitals would experience a 50 percent to 70 percent drop in coding productivity, with a somewhat lesser drop in coding productivity for other healthcare settings.[17] Some physician practices even predicted a productivity decline of greater than 40 percent.[18] While many providers experienced at least a slight decrease in productivity, others did not experience any impact.[19] For example, a June 2016 survey of coding professionals conducted by the AHIMA Foundation found only a 14 percent decrease in productivity. Nearly a third of respondents indicated either no change or an increase in coding productivity.[20]

Many organizations have indicated that their coding productivity levels are very close to the ICD-9-CM level and are continuing to improve.[21] Even among physician practices the productivity impact has been less than feared. In one survey of physician practices, 46 percent of administrative staff and 42 percent of clinical staff didn't see any productivity impact, and only 13 percent of administrative staff and 15 percent of clinical staff saw a significant impact on productivity.[22] For physician practices, the coder productivity impact seems to vary based on specialty, practice size, and the extent of opportunities to practice and gain proficiency with the new code set prior to the ICD-10 compliance date.[23] Understandably, practices not limited to a single specialty have a greater learning curve and greater initial loss of productivity.

Organizations that took a strong approach to training, performed ample dual coding, and had robust clinical documentation improvement programs saw smaller drops in productivity. The use of computer-assisted coding (CAC) technology is believed to have helped to mitigate productivity losses, with at least some CAC users reporting no drop in coder productivity.[24]

Significant declines in clinician productivity associated with additional documentation time were predicted, with most projecting at least a 10 percent increase in time spent on documentation. Although clinical documentation completion time has reportedly increased, for many organizations the impact on clinician productivity has not been as great as originally feared.[25] Clinician productivity is likely to continue to improve as clinicians become more accustomed to the new documentation requirements. Pre-implementation clinical documentation improvement strategies and EHR documentation prompts have helped to mitigate the impact of the ICD-10 transition on clinician productivity. And many clinical specialties have found that much of the expanded clinical detail in the code sections they typically use was already being documented (such as laterality).

Clinical Documentation Requirements that are Overly Burdensome

Prior to implementation of ICD-10 another prediction was that clinical documentation requirements to support the more specific ICD-10 codes would be overly burdensome. These predictions included:

- Unnecessarily detailed medical record documentation will be required
- Documentation requirements to support ICD-10 codes will be excessively burdensome
- Clinical documentation won't be sufficiently detailed to support the more specific ICD-10 codes

As noted earlier, however, laterality accounts for 46 percent of the increase in ICD-10-CM codes, and that information was typically documented prior to ICD-10 implementation.[26] New concepts in ICD-10-CM play a significant role in understanding severity, risk, comorbidities, causation, and other important parameters related to proper healthcare assessment and treatment.[27] Many of these new concepts are already, or should be, documented.

For example, it was suggested that the change in obstetric codes from capturing episode of care in ICD-9-CM to trimester in ICD-10-CM would require a complete change in clinical documentation.[28] The addition of the trimester information was specifically requested by the American Congress of Obstetricians and Gynecologists. This organization testified that the addition of this information would be valuable in efforts to monitor the provision of prenatal care and the occurrence of complications.[29] Given its clinical importance in the healthcare management of pregnant women, the trimester was typically documented even before the implementation of ICD-10.

Certainly, the number of physician queries has increased for many organizations since the ICD-10 transition. As noted earlier, however, clinical documentation improvement efforts and EHR documentation tools have facilitated documentation capture.

As stated in the final rule for the adoption of the ICD-10 code set standards, "Improved medical documentation is not predicated on the change from ICD-9 to ICD-10-CM. Rather, improved medical documentation is being driven by initiatives such as quality measurement reporting, value-based purchasing and patient safety. [HHS views] any potential improvements in medical record documentation as a positive outcome of the move to ICD-10-CM and ICD-10-PCS."[30] The need for accurate and specific health information continues to increase as a result of accountable care organizations and new payment and delivery reform models.[31]

Adverse Impact on Coding Accuracy

Some predicted that ICD-10 would adversely impact coding accuracy in the following ways:

- Significant decline in coding accuracy would occur for some period of time, possibly several years
- Use of unspecified codes would increase, thereby negating the value of moving to a more detailed code set

Although the industry-wide impact of ICD-10 on coding accuracy has not been widely-publicized, there are some indications that it has not been as negatively impacted, nor for as long, as was previously predicted. The June 2016 AHIMA Foundation study reported only a 0.65 percent decrease in accuracy.[32] In a post-implementation survey of billing companies, only two respondents reported a significant increase in coding errors, with 14 reporting no change in the coding accuracy rate (compared to pre-ICD-10 levels) and 11 reporting that coding was actually more accurate after ICD-10 implementation.[33]

Undoubtedly the extent of coder education influenced an organization's coding accuracy rate. In some cases, healthcare organizations found that coders either had forgotten or had never properly learned basic coding rules and concepts, so ICD-10 training actually improved coding accuracy to a higher level than before ICD-10.

The extent to which unspecified codes are being used varies by provider. More than half of the respondents to a post-implementation survey reported using the most specific ICD-10 codes all the time.[34] One payer reported a decline in the use of unspecified codes after the transition to ICD-10.[35]

Lack of Readiness

Predictions around a lack of industry readiness prior to the ICD-10 go-live included:

- Many HIPAA-covered entities wouldn't be ready
- CMS wouldn't be ready, and the ICD-10 transition would be another "healthcare.gov" debacle
- Non-HIPAA-covered entities wouldn't adopt ICD-10, causing administrative nightmares for providers
- Medicaid wouldn't be ready

- Testing was woefully inadequate

Since property and casualty insurers are not subject to the HIPAA regulations, and therefore not required to implement ICD-10, it was thought that these entities might not transition to ICD-10 on October 1, 2015, especially when state legislative or regulatory action had not been taken to align state requirements with federal regulations prior to the ICD-10 compliance date.[36] But payers and providers have reported no disruption in business processes post-ICD-10 implementation in those states that have not adopted ICD-10 regulations. Non-covered entities have generally been accepting ICD-10 codes even in the absence of state regulations requiring them to do so.[37]

Concerns were expressed that CMS' testing was not extensive enough to properly assess CMS and industry readiness as well as be able to identify and correct problems. However, CMS' testing results were consistently very positive, and the widespread ability of providers to successfully submit claims—and of CMS to accept them—demonstrates that testing was adequate. The fact that commercial payers have experienced few issues as well demonstrates that their testing was also sufficient. Given the minimal problems following the transition, CMS and Medicaid programs were clearly ready.

Other Predictions

Some other ICD-10 predictions that were made before its implementation included:

- The ICD-10 transition would be prohibitively expensive, especially for small providers
- A hard cut-over on a single date would create widespread problems
- Organizations would experience major disruptions in business operations
- ICD-10-PCS would replace CPT
- ICD-10 would never be implemented

The predictions noted above also did not come to pass. Although large healthcare organizations expended significant resources toward ICD-10 implementation, each delay exponentially increased the cost. For small providers, the transition appears to have been manageable and less costly than some of the estimates. One estimate suggested the total transition cost could be as high as $226,000 for a small physician practice and $8 million for a large practice.[38]

Some industry stakeholders felt that a "grace period" was necessary—whereby either ICD-9-CM or ICD-10 codes could be submitted for a date of service after the ICD-10 compliance date—in order to avoid issues associated with a cut-over on a single compliance date. But issues resulting from a single compliance date failed to materialize.

While some providers reported negative impacts in the areas of coding, clinical documentation, and authorization/precertification requests, major disruptions to business operations have not occurred.[39] In fact, some health plans reported a positive impact in the areas of claims validation, post-payment reviews, and data analysis.[40]

Obviously, ICD-10-PCS has not replaced CPT despite fears to the contrary.

Did Delays Positively or Negatively Affect the ICD-10 Transition?

It has been suggested that many of the dire predictions did not transpire because the multiple delays provided the healthcare industry more time to prepare, thus leading to a smoother transition. But many providers did not take advantage of the additional time. Delays added implementation cost and loss of momentum. The cost of just a one-year delay was estimated to be a 30 percent increase in total ICD-10 implementation costs, or $6.8 billion across the healthcare industry.[41] For at least some healthcare organizations, delaying the transition from 2014 to 2015 was expected to cost more than complying in 2014 would have.[42]

The delay turned out to be self-perpetuating in that it caused further delay.[43] Each delay was disruptive for healthcare delivery innovation, payment reform, public health, and healthcare spending.[44] Uncertainty around further delays was identified by many organizations as a primary obstacle to ICD-10 implementation.[45] Two-thirds of providers responding to a pre-implementation survey reported that they slowed down implementation activities or placed them on hold as a result of the delay.[46] Similarly, nearly two-thirds of physician practices responding to another survey reported that they paused their ICD-10 implementation efforts as a result of the last delay. Of the group of respondents that had not yet started to prepare by the

beginning of 2015, 30 percent believed the deadline would be pushed back again or they believed they could prepare just a few months prior to the compliance date.[47]

Once it became clear that the compliance date was not going to change again, stakeholders stepped up their preparation efforts—suggesting that the same level of effort might have been achieved to meet an earlier compliance date. Interestingly, 60 percent of medical practices responding to an online poll indicated that in retrospect they didn't think the one-year delay from 2014 to 2015 in ICD-10 implementation was necessary.[48]

Lessons Learned from the ICD-10 Transition

The ICD-10 transition has been compared to Y2K due to the expectations for Armageddon-like catastrophic consequences that in reality fell flat. By all reports, the transition went very well.[49] Negligible impacts to day-to-day business as a result of the ICD-10 transition were reported.[50] Some clinicians have even characterized the transition as a "piece of cake," and have observed that ICD-10 codes allow clearer communication regarding the types of conditions being treated.[51]

The ICD-10 transition was not completely free of glitches. Some stakeholders have experienced systems glitches, claims processing errors, payment policy translation errors, and issues with EHR ICD-10 code look-up tools. But problems have been minor or limited in nature, resolved quickly, and/or not led to widespread disruption. Also, some reported issues are not directly related to ICD-10, such as EHR design and functionality problems.

Post-implementation issues included:

- Clinical documentation deficiencies
- Increase in physician queries
- Inadequate physician education
- Incorrect translation of some payer policies
- Incorrect claims edits
- Poorly designed EHR coding tools that have caused clinician frustration or led to incorrect or nonspecific code selection
- Physician orders for ancillary services that contained ICD-9-CM codes

The relatively smooth transition for most of the healthcare industry has been attributed to extensive planning, education, and preparation.[52] Larger and better-prepared organizations experienced the smoothest transition, demonstrating that thorough preparation, adequate education, clinical documentation improvement efforts, and proper testing paid off. Factors contributing to a successful ICD-10 implementation included early planning, early and extensive training and coding practice, effective internal and external communications, extensive internal and external testing, industry-wide collaboration, and HHS' committed leadership. Having EHR and practice management systems in place helped to simplify the transition due to the inclusion of ICD-10 codes and mapping suggestions.[53]

CMS should be commended for their key role in the smooth transition to ICD-10. They were well-prepared, proactive, and responsive to the industry. CMS conducted extensive ICD-10 outreach, education, and testing. In addition, they developed many tools and resources, including ICD-10 implementation guides, checklists, action plans, and tools specifically designed for small and rural providers.

What lessons can be learned from this experience that might be applied to future adoption of new or modified HIPAA standards? One lesson learned is that aggressive outreach and education, provided early and often, are critical to industry preparedness, especially for those stakeholders most at risk. Education should be targeted to the audience, focused on the positives and not feeding fears, and should not be overwhelming. Educational tools should be simple and make the transition to a new standard easy, not complicated, confusing, or inclusive of information irrelevant to the user. Outreach should involve not just government agencies and national organizations, but also local communities. Larger healthcare organizations should reach out to provide assistance to smaller entities in their communities, as it is in all stakeholders' best interest for everyone to be well-prepared—lack of readiness on the part of some entities risks industry-wide disruption.

Early, active engagement and commitment by all stakeholders is critical. Early and extensive engagement of the physician community and early involvement of physician champions could have helped to disseminate accurate information about the transition and minimize the scope and damaging effect of misinformation. Simple, concise, clear, positive messaging with

targeted messages for different audiences is essential. Communication of success stories and best practices helps to mitigate fears about the implementation process and reduces the resistance to change. Simple, creative tools that make the change easy, affordable, efficient, and effective, especially for small providers with limited time and resources, also help to ensure a smoother transition, increase stakeholder buy-in, and lessen resistance to change.

Clear implementation milestones and metrics should be established in order to measure progress and assess readiness for the transition to a new standard. Communicating principles for effective testing would be beneficial.

The process of replacing ICD-9-CM with the ICD-10 code sets began more than 15 years ago. With the rapid changes in the healthcare environment and increasing reliance on detailed healthcare data, it will be unacceptable in the future for the process of adopting updated versions of code set standards to once again take that long. Legislative changes may be needed to address many of the cumbersome HIPAA process requirements that currently impede timely updates of HIPAA standards.

While preparing for the ICD-10 transition may be finished, the post-implementation monitoring and continuous improvement phase is not over. Healthcare organizations should continue to assess their progress and quickly identify and resolve any issues that may still arise. Claims denials and rejections, reimbursement, clinical documentation improvement, coding productivity and accuracy, and other relevant key performance indicators (KPIs) should continue to be monitored. Continuation of targeted coding education and clinical documentation improvement activities will help to improve coding accuracy and productivity, ensure proper reimbursement, and reduce claims rejections and denials. See CMS' ICD-10 Next Steps Toolkit for excellent tools and information to assess ICD-10 progress using KPIs, available at https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10NextStepsToolkit20160226.pdf.

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